THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-6503.M5

MDR Tracking Number: M5-04-0436-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-10-03.

The IRO reviewed neuromuscular re-education, therapeutic exercises, massage therapy, iontophoresis, supplies and materials, electrical stimulation, myofascial release, joint mobilization, measure of blood oxygen level and office visits rendered from 12-20-02 through 04-30-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
2-3-03 through 4-30-03 (26 DOS)	99211, 99213	$560.00 (1 unit @ $20.00 X 25 DOS, 1 unit @ $60.00 X 1 DOS)	$0.00	U	$18.00 (25 DOS) $48.00 (1 DOS)	IRO Decision	IRO recommended one (1) office visit per month. Reimbursement recommended in the amount of $18.00 X 2 and $48.00 X 1 = $84.00
1-31-03 through 4-18-03 (21 DOS)	97112	$840.00 (1 unit @ $40.00 X 21 DOS)	$0.00	U	$35.00	IRO Decision	Reimbursement recommended in the amount of $35.00 X 21 DOS = $735.00
1-31-03 through 4-18-03 (20 DOS)	97250	$1,000.00 (1 unit @ $50.00 X 20 DOS)	$0.00	U	$43.00	IRO Decision	Reimbursement recommended in the amount of $43.00 X 20 DOS = $860.00
1-31-03 through 4-18-03 (23	97265	$1,150.00 (1 unit @ $50.00 X 23 DOS)	$0.00	U	$43.00	IRO Decision	Reimbursement recommended in the amount of $43.00 X 23 DOS = $989.00

DOS)							
12-20-02 through 4-18-03 (24 DOS)	97110	$2,680.00 (1 unit @ $40.00 X 67 units)	$0.00	U	$35.00	IRO Decision	Reimbursement recommended in the amount of $35.00 X 67 units = $2,345.00
4-1-03	94760	$60.00 (1 unit)	$0.00	U	$52.00	IRO Decision	No reimbursement recommended.
4-23-03 through 4-30-03 (4 DOS)	97110	$360.00 (1 unit @ $40.00 X 9 units)-	$0.00	U	$35.00	IRO Decision	No reimbursement recommended.

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
4-23-03 through 4-30-03 (3 DOS)	97112	$120.00 (1 unit @ $40.00 X 3 DOS)	$0.00	U	$35.00	IRO Decision	No reimbursement recommended.
4-23-03 through 4-30-03 (3 DOS)	97250	$150.00 (1 unit @ $50.00 X 3 DOS)	$0.00	U	$43.00	IRO Decision	No reimbursement recommended.
4-23-03 through 4-30-03 (3 DOS)	97265	$150.00 (1 unit @ $50.00 X 3 DOS)	$0.00	U	$43.00	IRO Decision	No reimbursement recommended.
4-28-03	97032	$25.00 (1 unit)	$0.00	U	$22.00	IRO Decision	No reimbursement recommended.
4-28-03	97033	$25.00 (1 unit)	$0.00	U	$22.00	IRO Decision	No reimbursement recommended.
4-28-03	97124	$35.00 (1 unit)	$0.00	U	$28.00	IRO Decision	No reimbursement recommended.
4-28-03	99070	$20.00 (1 unit)	$0.00	U	DOP	IRO Decision	No reimbursement recommended.
TOTAL		$7,175.00					The requestor is entitled to reimbursement of **$5,013.00**

The IRO concluded that treatment beyond date of service 04-18-03 which included measurement of blood oxygen level, electrical stimulation, massage therapy, ionophoresis and supplies and materials and office visits beyond one per month **were not** medically necessary. The IRO concluded that one office visit per month, neuromuscular re-education, myofascial release, joint mobilization and therapeutic exercises from 12-20-02 through 04-18-03 **were** medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees **($5,013.00)**. Therefore, upon receipt of this Order and in accordance with

§133.308(r)(9) the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-26-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
12-20-02 and 2-28-03 (2 DOS)	99211	$40.00 (1 unit @ $20.00 X 2 DOS)	$18.00 paid DOS 12-20-02	F	$18.00	Rule 133.307 (g)(3)(A-F)	Respondent paid MAR for DOS 12-20-02. Requestor did not submit relevant information to support delivery of service for DOS 2-28-03. No reimbursement recommended.
12-20-02	97010	$15.00 (1 unit)	$0.00	F	$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $11.00
12-20-02	97032	$25.00 (1 unit)	$0.00	F	$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $22.00
12-20-02	99070	$20.00	$0.00	N	DOP	96 MFG GENERAL INSTRUCTIONGR (III)(A)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
12-20-02 and 2-28-03 (2 DOS)	97110	$160.00 (4 units)	$35.00 paid DOS 12-20-02	F	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
12-20-02	97033	$25.00 (1	$0.00	F	$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to

		unit)					support delivery of service. Reimbursement recommended in the amount of $22.00
2-14-03	99211	$20.00 (1 unit)	$0.00	R	$18.00	96 MFG E/M GR (VI)(B)	R – No TWCC 21 on file. Reviewer will review per 96 MFG. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $18.00
2-14-03 and 3-12-03 (2 DOS)	97110	$280.00 (7 units)	$0.00	D	$35.00	Rule 133.307 (g)(3)(A-F)	D – Neither requestor nor respondent provided original explanation of benefits. See rationale below. No reimbursement recommended.

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$**	**Reference**	**Rationale**
2-14-03	97250	$50.00 (1 unit)	$0.00	R	$43.00	96 MFG MEDICINE GR (I)(9)(c)	R – No TWCC 21 on file. Reviewer will review per 96 MFG. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $43.00
2-14-03	97265	$50.00 (1 unit)	$0.00	R	$43.00	96 MFG MEDICINE GR (I)(9)(c)	R – No TWCC 21 on file. Reviewer will review per 96 MFG. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $43.00
2-14-03	97112	$40.00 (1 unit)	$0.00	D	$35.00	Rule 133.307 (g)(3)(A-F)	Neither requestor nor respondent provided original explanation of benefits. Reviewer cannot determine reason for denial. No reimbursement recommended.
4-22-03	99212	$40.00 (1	$0.00	G	$32.00	96 MFG E/M GR (VI)(B)	G- Not global to any other service billed on DOS.

		unit)					Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $32.00
4-22-03	A4550	$45.00 (1 unit)	$0.00	F	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support DOP criteria. Reimbursement recommended in the amount of $45.00
4-22-03	J2000	$30.00 (1 unit)	$0.00	F, G	DOP	Rule 133.307 (g)(3)(A-F)	G- Not global to any other service billed on DOS. Requestor submitted relevant information to support DOP criteria. Reimbursement recommended in the amount of $30.00
4-22-03	A4208	$10.00 (1 unit)	$0.00	F, G	DOP	Rule 133.307 (g)(3)(A-F)	G- Not global to any other service billed on DOS. Requestor submitted relevant information to support DOP criteria. Reimbursement recommended in the amount of $10.00

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$**	**Reference**	**Rationale**
4-22-03	A4200	$5.00 (1 unit)	$0.00	F, G	DOP	Rule 133.307 (g)(3)(A-F)	G- Not global to any other service billed on DOS. Requestor submitted relevant information to support DOP criteria. Reimbursement recommended in the amount of $5.00
TOTAL		$855.00	$53.00				The requestor is entitled to reimbursement in the amount of $281.00

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set

forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Decision is hereby issued this 17th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 12-20-02 through 04-30-03 in this dispute.

This Order is hereby issued this 17th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

January 13, 2004
Amended May 10, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #:	M5-04-0436-01
IRO #:	5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Physical Medicine and Rehabilitation.

The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ fell at work on ___ and sustained an injury to her right shoulder. She underwent arthroscopy decompression acromioplasty, and partial rotator cuff repair on 2/3/95. She had persistent right shoulder pain. In 2002 she saw a new surgeon and after unsuccessful physical therapy and repeat imaging studies, she underwent a repeat arthroscopic rotator cuff repair on 11/20/02. She began post-op physical therapy for the right shoulder on 12/2/02. An attack of shingles interrupted treatment on 12/20/02 and she resumed shoulder rehabilitation on 1/28/03. She finished rehab on 3/14/03 but was restarted on 4/1/03 after hr surgeon ordered six more weeks of therapy. She completed her rehab on 5/2/03.

DISPUTED SERVICES

Under dispute is the medical necessity of neuromuscular reeducation, therapeutic exercises, massage therapy, iontophoresis and supplies and materials, electrical stimulation, myofascial release, joint mobilization, measure of blood oxygen level and office visits.

DECISION

The reviewer both agrees and disagrees with the prior adverse determination.

The reviewer found medical necessity for one office visit per month, neuromuscular reeducation, myofascial release, joint mobilization and therapeutic exercises provided through 4/18/03.

The reviewer did not find medical necessity for treatment beyond 4/18/03 or for the measurement of this patient's blood oxygen level. This includes electrical stimulation, massage therapy, ionophoresis and supplies and materials, also, office visits beyond 1x per month were not found to be medically necessary.

BASIS FOR THE DECISION

The myofascial release, joint mobilization and therapeutic exercises were reasonable and medically necessary until 4/18/03. Given the patient's age and the interruption of rehab due to the shingles, continuation of an active rehab program for the right shoulder for approximately three months of actual treatment was appropriate and necessary based on generally accepted care standards (1). However, it appears from the physical therapy notes that the patient likely reached maximum medical benefit from treatment by 4/18/03. Treatment after that date does not appear medically necessary for the patient's functional improvement.

The measurement of blood oxygen level does not appear a medically necessary as part of the patient's shoulder rehabilitation program.

Office visits charged for each therapy session are not reasonable, customary or medically necessary for administering a post-operative shoulder rehabilitation protocol. An office visit no more frequently than monthly is medically appropriate.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,

(1) Jobe FW, Schwab DM, Wilk K, Andrews, JR. Rehabilitation of the shoulder. In Brotzman SB (ed) Handbook of orthopedic rehabilitation St. Louis: Mosby, 1996; 103-128.